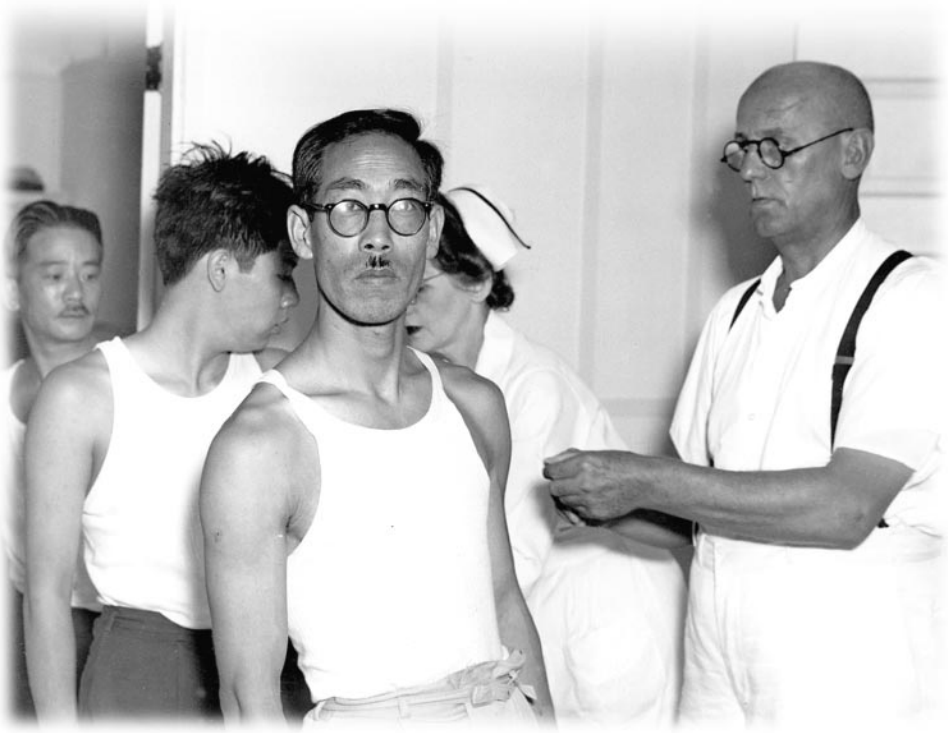
Medical Care for Interned Enemy Aliens:

A Role for the US Public Health Service in World War II

During World War II, the US Public Health Service (USPHS) administered health care to 19 000 enemy aliens and Axis merchant seamen interned by the Justice Department through its branch, the Immigration and Naturalization Service (INS).

The Geneva Prisoners of War Convention of 1929, which the United States applied to civilian internees, provided guidelines for belligerent nations regarding humanitarian treatment of prisoners of war, including for their health. The INS forged an agreement with the USPHS to meet these guidelines for the German, Italian, and Japanese internees and, in some cases, their families. Chronic shortages and crowded camps continuously challenged USPHS administrators.

Nevertheless, the USPHS offered universal access to care and provided treatment often exceeding care received by many American citizens.



Source. Immigration and Naturalization Service.

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DURING WORLD WAR II, the United States confined behind barbed wire fences nearly 140 000 noncombatants. The imprisonments began in September 1939 with the detention of German merchant seamen who had maneuvered their ships into neutral ports to avoid seizure by British and French naval forces awaiting them in international waters. The climax came in the spring of 1942 with the forced removal by the army of nearly 120 000 Japanese Americans and their immigrant elders from their homes in the West Coast states.

Most scholarship on the wartime fates of these civilian groups has centered on the incarceration of Japanese Americans, which a presidential commission in 1982 concluded was based on racial prejudice, war hysteria, and a failure of political leadership.[1] However, this essay focuses on a different issue: the internment of 19 000 Axis seamen, US resident enemy aliens, and Axis nationals deported from Latin America at the request of the State Department. Political status distinguished the internees as a group from the incarcerated Japanese Americans. While the incarceration order originated from an executive order (EO 9066), the government's authority to intern enemy aliens derived from the US Code.[2] Moreover, the model for humane treatment of internees came from the Geneva Prisoners of War Convention of 1929, which most nations had ratified, including the United

States, and to which nonsignatory Japan promised de facto compliance. Compliance with this international agreement may explain why camp life was often more comfortable for the internees than for Japanese Americans.

In the spring of 1941, as transfers of German and Italian seamen to newly established Immigration and Naturalization Service (INS) detention camps began in earnest, the INS possessed neither the financial resources nor expertise to meet the basic health needs of noncombatant crew members, which had reached 1700 after Italy joined forces with Germany in June 1940. Only days before the United States entered the war on December 8, 1941, did the INS have in place a working plan that would provide health services for the mariners as well as for US resident enemy aliens who would soon be pouring into its immigration stations.

The INS and the US Public Health Service (USPHS), to whom this new arm of the Justice Department[3] turned for assistance, forged a cooperative partnership that endured throughout the war. But it was a bipartisan effort chronically plagued by scant human and medical resources. The 2 federal agencies struggled to stave off high morbidity and mortality rates that, if known by the enemy, might lead to reprisals against an estimated 20 000 American civilians interned behind enemy lines in Europe and Asia.

Health resources were scarce on the home front. Nearly one third of the nation's youngest and most energetic doctors entered active duty, and hospital wards shut down for lack of essential auxiliary staff. Nevertheless, more than 1700 interned Axis seamen, 800 German, Italian, and Japanese resident enemy aliens and their families, and 2700 deportees from Latin America and their families all received access to health care. This care included inoculations to prevent dreaded epidemic diseases, outpatient and inpatient care, dental and optometry services, and, at times, sophisticated surgical procedures in hospital settings. The role played by the Public Health Service in providing health services was essential to the INS, enabling administrators to complete their mission.

DETENTION OF AXIS SEAMEN

On May 9, 1941, after a 3-day journey by train from the Ellis Island immigration station, 125 sleepy seamen from the ex-Italian liner *Conte Biancamano*, seized in the Panama Canal Zone 11 months earlier, stumbled off the coaches and into the hands of the INS Border Patrol at the Fort Missoula, Mont, detention station. The group was part of a contingent of Italian mariners that would reach one thousand before the end of the year.

To the south, 411 seamen from the scuttled German liner *S.S. Columbus* were already settled into barracks on the USPHS reservation at Fort Stanton, NM.[4] And to the east, at Fort Lincoln, near Bismarck, ND, 220 German merchant crewmen from seized freighters, tankers, and other merchant vessels were taking up residence on a military post that was being converted to INS use.[5]

Earlier efforts to return the seamen to Europe had failed for lack of shipping and of guaranteed safe passage. This left the INS in the unwanted role of caretaker until they could be repatriated. The new wards found themselves dependent upon the US Government for food, shelter, clothing, necessary diversions to maintain morale, and maintenance of their physical health.

Fortunately, existing infrastructure saved the INS from having to build a medical program from scratch. The former cavalry post at Fort Stanton, acquired in 1896 by the USPHS, was the site of an active marine hospital originally built to care for tubercular merchant seamen. It stood several hundred yards from the detainees' sleeping quarters.[6] At Fort Lincoln, an army medical staff had been operating a 60-bed hospital and was now under orders to assist the INS with its transfer to civilian use. A 50-bed hospital stood on the grounds of a former military reservation at Fort Missoula, although a fire had recently shut down operations before the INS took it over.[7]

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Missing from the INS armamentarium, however, was the necessary know-how to dispense medical care. Therefore, in April 1941, shortly after taking custody of the detained seamen, the INS initiated contact with the Public Health Service, under the naïve assumption that the service would step in with existing personnel and a flexible budget as part of its ongoing mission to safeguard the nation's health.

Opposite left: Japanese internees receiving inoculations by a USPHS nurse and her assistant.

THE USPHS BECOMES INVOLVED

The US Public Health Service had enjoyed a long history of helping government agencies solve their public health needs. Beginning in 1892, for example, USPHS physicians provided mandated health inspections of all immigrants attempting to enter the United States at Ellis Island, NY. It later performed a similar function at the Angel Island immigration station in San Francisco Bay for immigrants from Asia.[8] In 1930, following creation of the Federal Bureau of Prisons, the service took over the health care program for more than 12 000 inmates at the 7 existing federal prisons then in the correctional system.[9]

The USPHS began to speculate on its future role in the defense of the nation as early as May 1939, when Surgeon General Thomas Parran asked the War Department how the Army General Staff might wish to employ his organization in time of war. Following the outbreak of war 4 months later, a formal relationship was created between the service and the War Department when it was called upon to protect the health of military personnel by maintaining sanitation standards in connection with large concentrations of troops on maneuvers.[10]

In the spring of 1941, the service was called upon to assist a civilian agency in safeguarding the health of noncombatant detainees. Interestingly, this role would surpass in scope its future assignments of assisting the army and the War Relocation Authority in planning for and carrying out the incarceration of Japanese Americans. This was due to the presence of many practicing physicians among the ranks of the Japanese in the army-run assembly centers and also because the War Relocation Authority was unwilling to relinquish control of any of its responsibilities to an outside agency.[11]

On April 24, 1941, W.F. Kelly, chief supervisor of the Border Patrol, telephoned Dr Frank Thweatt, Jr, assistant to Surgeon General Thomas Parran, to request aid in surveying the sanitary facilities at Fort Missoula and to seek advice on expanding the camp. Thweatt promised help. Kelly pressed further, suggesting that the service also take over responsibility for maintenance and operation of the hos-

Fort Lincoln around 1941.

pital. At this point, Parran's assistant balked, thereby setting the stage for a 7-month negotiation that drew the personal attention of the surgeon general and the attorney general.[12]

Thweatt's behavior indicated no attempt to be uncooperative. His position merely reflected the service's lack of available human and financial resources. On the eve of World War II, the USPHS employed fewer than 2000 full-time medical officers throughout the nation, with state and local health departments scrambling to fill 500 vacancies.[13] Consequently, with the military's increasing need for younger physicians, the service lowered physical standards and relaxed age restrictions for its reserve officer corps and began to recruit doctors aged older than 45 years. This policy compromised its ability to provide energetic and competent personnel beyond its own immediate needs.[14] In addition, the service had no budgetary authority to provide more than short-term, emergency assistance to outside agencies. The INS would have to go it alone.

But the INS made little headway procuring full-time medical personnel. No qualified medical doctor could be found among the German crews to assist the lame-duck army medical staff at Fort Lincoln, forcing the new INS camp commander, A.S. Hudson, to solicit part-time contracts in the surrounding communities. However, a long-standing distrust by physicians of government intrusion into the affairs of the medical profession caused the local medical society to oppose its members' entering into contract negotiations. As a result, Hudson had just a single drugstore owner in tow by midsummer, to dispense pharmaceuticals. Bismarck's St. Alexis Hospital agreed to admit detainees, but only at prevailing rates and without priority. Only Hudson's coaxing and subsequent intervention by the state medical association broke the impasse.[15]

At this point, frustrated Acting Attorney General Francis Biddle became involved when he personally implored Surgeon General Parran to step in and help resolve the problem.[16] Personal persuasion aside, any long-term cooperation centered on the Justice Department agreeing to provide reimbursement for all personnel and associated costs.[17] And this would require special appropriations from Congress.

Source. Immigration and Naturalization Service.

German merchant seamen at the laundry tubs at Fort Lincoln.

Source. Immigration and Naturalization Service.

STAFFING THE CAMP HOSPITALS

Problems associated with employing contract physicians on a part-time basis would soon become apparent. Overworked private practices competed with daily sick call and hospital rounds for detainee patients. In addition, the Germans, locked up in alien surroundings and many unable to speak English, were distrustful of Americans and of American doctors and their doctoring.

The August 1941 arrival of detainee physician Ludovicko Borovicka from Fort Missoula raised hopes that Fort Lincoln's staffing problem might be alleviated. Austrian by birth but an Italian in the political aftermath of World War I, Borovicka, aged 50, was a well-trained clinician with research interests in venereal diseases, tuberculosis, cancer, and tropical diseases. Arrested and detained on an immigration violation in January 1941, he joined the Italian seamen in the Montana dry lands. Borovicka took over the medical service at Fort Lincoln after the reassignment of the army medical staff in July 1941. A consummate professional fluent in German, he soon gained the trust of his patients and the confidence of INS administrators. The German Government soon rewarded the highly motivated Borovicka with a detainee officer's pay of $2.50 per week and later accolades for good service.[18]

By September 1941, the INS finally secured contracts with physicians, druggists, and local hospitals, guaranteeing the availability of health care for detainees at both Fort Lincoln and Fort Missoula. Work was under way to repair the fire-damaged hospital at Fort Missoula. For its part, the USPHS had consulted on sanitation, immunizations, isolation facilities, and other means to prevent the spread of disease.

Finally, on December 5, 1941, the surgeon general and the attorney general reached an understanding whereby the USPHS would supply the medical personnel and all medical expertise while the INS would provide overall administration and pay the bills.[19] The USPHS was clearly the linchpin in safeguarding the health of the Axis seamen under INS jurisdiction.

THE USPHS AND THE INS ENTER THE WAR

That the INS had 8 months to plan its internment program before the country suddenly plunged into World War II was fortunate because, after December 7, 1941, planners had to turn their attention to a new

group of noncombatants heading their way: US resident German, Italian, and Japanese enemy aliens currently being rounded up from coast to coast by the Federal Bureau of Investigation (FBI) and turned over to the INS. The alien Japanese detainees among the group represented the elite in their prewar communities on the West Coast. Their sudden departure left the communities leaderless because the American-born generation had not yet come of age. By December 9, the INS had 1792 "alien enemies" in custody. The number reached 3005 by the end of the year.[20]

Immigration stations throughout the country quickly filled with the overflow spilling into temporary detention stations in Pittsburgh, Miami, San Francisco, and elsewhere. Larger, permanent detention camps were clearly required, similar to those at Fort Missoula, Fort Lincoln, and Fort Stanton. The first to open was at Santa Fe, NM, which initially held 426 Japanese males from southern California. A former Civilian Conservation Corps camp at Kenedy, Tex, opened in March 1942 for male deportees from Latin America, while in April the INS took over a federal prison at Seagoville, Tex, to house female enemy aliens and their children. The following December, a family camp at Crystal City, Tex, took in the first group of wives and children who chose voluntary internment in order to be reunited with their husbands and fathers.

In all, the INS operated 7 permanent detention camps (and more than 2 dozen temporary camps), whose populations ranged from 425 at Fort Stanton to 3374 in 1944 at the family camp at Crystal City (Table 1).[21] Historian Roger Daniels estimates that 20 000 Axis nationals were eventually interned by the United States in World War II from among the one million nonnaturalized natives considered a potential threat to national security.[22]

THE GENEVA PRISONERS OF WAR CONVENTION

Underpinning the INS internment program in World War II was the Geneva Prisoners of War Convention of 1929, which provided belligerent nations necessary guidelines for humanitarian treatment of prisoners of war. With the United States now in the war, these provisions were extended to all noncombatants under its custody. Secretary of State Cordell Hull proposed to his German, Italian, and Japanese counterparts that their governments reciprocate in kind. Such an agreement among nations would provide some measure of assurance that interned civilians were treated humanely. The belligerents provided only limited assurances, thus increasing pressure on the United States to follow the guidelines of the Geneva Convention to the letter.[23]

As the Geneva Convention's provisions pertained to health matters, subscriber nations were bound to provide healthful and sanitary environments for their prisoners and freedom from epidemics. These measures included monthly sanitary inspections. All camps were required to provide operational infirmaries with isolation quarters for contagious cases. Compatriot medical personnel, when available, must be permitted access to the prisoners. Finally, for severe illness or complicated surgical needs, prisoners must be allowed admittance to

Table 1—Permanent Internment Camps Operated by the Immigration and Naturalization Service During World War II

Camp	Nationality of Internees	Peak Population (est)	Years in Operation
Fort Missoula, Mont	Italian seamen	1000	1941–1945
	Japanese nationals	750	
Fort Lincoln, ND	German seamen	450	1941–1947
	Japanese nationals	600	
	Japanese American renunciants	650	
Fort Stanton, NM	German seamen	425	1941–1945
Santa Fe, NM	Japanese nationals	2100	1942–1946
Kenedy, Tex	German nationals	325	1942–1944
	Japanese nationals	300	
Crystal City, Tex[a]	German nationals	1000	1942–1947
	Japanese nationals	2100	
	Italian nationals	250	
Seagoville, Tex[a]	German nationals	400	1942–1945
	Japanese nationals	100	

[a]Family camp.

military or civil institutions qualified to treat them.[24]

The primary burden for implementing these medical guidelines fell to USPHS personnel. Their duty assignment was clear: provide the best medical care possible under wartime conditions and avoid medically related incidents that might lead to reprisals against the 20 000 American noncombatants interned by the enemy in Asia and Europe.

THE PUBLIC HEALTH SERVICE TAKES OVER

Shortly after the United States entered the war, the USPHS shuffled its nursing corps assignments in order to staff the temporary immigration stations in greatest need, and it gradually commissioned medical officers to run the permanent hospitals. The service ultimately staffed, equipped, and administered all clinics and hospitals and provided the bulk of clinical care for the internees. The INS, in turn, provided the facilities and overall administration, and it bore all costs through special appropriations from Congress.

In January 1942, acting assistant surgeon Leonard B. Moyer reported to Fort Lincoln, where he would remain as chief medical officer for the next 4 years. Moyer was a reserve officer in the Army Medical Corps and, at 36, was nearing the 37-year-old age limit. With the USPHS now loosening its age requirements for its reserve officer corps, Moyer found an opportunity to continue public service. Initially, the Nebraska College of Medicine graduate served as a part-time medical officer, enabling him to maintain a part-time private practice in nearby Bismarck. Moyer attended daily sick call, made hospital rounds, and was on 24-hour call.

Unfortunately, some tenures ended less successfully than Moyer's. The physical demands tested the endurance of older public health physicians, some of whom had come out of retirement. Others attempted public service while juggling busy part-time practices. Moreover, the permanent camps were located in isolated areas with few amenities. Rigors of the job and the austere environment posed a stiff challenge to the service to recruit qualified and dedicated personnel for its facilities, including the Crystal City internment camp hospital in south Texas.

Construction began there in November 1942 to convert a migratory farm labor camp into a barbed wire community where interned enemy aliens could be voluntarily reunited with their families. Among them were wives and children of deportees from Latin American countries.[25]

Two USPHS nurses were on hand to greet the first group of 130 German adults and children who arrived in December 1942. The pair organized a 2-room dispensary while a contract physician and dentist provided emergency care. A newly appointed medical officer, Symmes Oliver, arrived in January 1943, and a dental officer followed in February. With a German internee physician among the ranks, the staff initiated a program to train orderlies and nurses aides, with Oliver in charge.

Oliver was a career clinician in relatively poor health who was looking for a less stressful professional situation that would ease him into retirement. He therefore responded to the Public Health Service call for recruits into its reserve officer corps.

The presence of women and children, especially Latin Americans who frequently brought with them contagious diseases, produced special health problems for the medical staff not seen at other camps dominated by male internees. The first medical crisis occurred in February, following the arrival of 131 German nationals from Costa Rica who had been held briefly at the San Pedro Immigration Station, near Los Angeles. Fifty-five cases of children's whooping cough were discovered by Oliver and his staff, as well as 8 cases of impetigo. Two children arrived with acute medical needs requiring immediate, outside hospitalization. Most of the adults suffered from severe respiratory ailments. In all, 66 needed immediate medical attention, and it was feared that others who manifested symptoms of simple colds might turn into medical cases.[26]

Because these contagious conditions threatened the entire camp, internees and staff alike, Oliver ordered the Costa Ricans quarantined for the duration of the crisis, while immunizing 29 asymptomatic children considered still at risk for whooping cough. He later criticized the medical officer at San Pedro for failure to initiate quarantine measures and for permitting a trainload of contagion to threaten a camp with no functioning hospital, let alone an isolation ward.[27]

STAFF WOES

After the crisis abated, Oliver initiated an extensive immunization program that provided protection for nearly every internee passing through the gates. But this public health work proved to be Oliver's high water mark. Soon complaints circulated about the 50-year-old former private practitioner, with alcohol abuse and bouts of depression at their root. His detractors accused him of publicly criticizing coworkers and of being unable to supervise his staff. He demonstrated poor leadership, with subordinates assuming responsibilities that should have been his. According to his accusers, he instilled little confidence in either staff or patients by his hesitancy to act on clinical matters and his refusal to perform surgery.[28]

In light of the heavy medical caseload, exacerbated by an increasing number of families in poor health from Latin America and the growing responsibilities associated with the opening of a 70-bed hospital, the INS central office initiated efforts to replace Oliver with a qualified surgeon. Resolution, however, lagged. The American medical officer at Fort Missoula possessed the needed skills, but his transfer to the family camp would solve one problem only to produce another with his departure. For the time being, Oliver had to stay. In the meantime, a competent nursing staff and several internee physicians helped the hospital to remain afloat amidst a rapidly expanding camp population.[29]

Administrators relied heavily on internee physicians willing to practice their profession while in captivity. In addition to offering sorely needed manpower, having on hand a doctor of the same nationality and ethnicity as the internees helped with trust building and may ultimately have increased appropriate health-seeking behaviors. But staffing a hospital with Americans working alongside internee physicians whose captors perceived them as the enemy had its downside. Having Americans in subordi-

nate staff positions, forced to accept orders from enemy alien doctors, could lead to open conflict and loss of morale. The INS therefore committed itself to placing American medical officers in all supervisory positions.

DR LUDOVICKO BOROVICKA

The experience of the INS with Dr Borovicka may have informed this revised policy. Borovicka could not qualify to practice his profession in Mussolini's Italy. He left the country in 1927, arriving in the United States in 1929. There he practiced medicine in New York City until 1932. At that time, he presented fraudulent first citizenship papers. As a result, he was deported to Italy in 1933 but reentered the country illegally in 1937. Prior to his arrest in January 1941, which led to his detention at Fort Missoula, he held several positions in tuberculosis sanitoria throughout the United States. Thus, Borovicka was well acquainted with the current American medical system, and his transfer from an Italian to a German camp seemed logical because of his Austrian roots.

For a time, hospital operations went smoothly. Conflicts, however, soon arose. Borovicka's haughty manner influenced working relationships with subordinates and led to the resignation of one of the hard-to-come-by USPHS nurses. An adversarial relationship continued with the chief nurse, who remained on staff. Dr Moyer's arrival in January 1942 led to Borovicka being stripped of his authority and ultimately banished from the hospital.[30] A later attempt to farm out the highly skilled physician to Fort Stanton came to naught when Captain Wilhelm Daehne, spokesman for the *Columbus* crew, opposed the transfer because of concern that Borovicka was neither German nor part of the German seamen's maritime culture.

Borovicka next offered his services as a researcher to the USPHS, but he was turned down because of an outstanding deportation warrant. Thus sat idle an able and clever man in possession of desperately needed talents, but burdened by the politics of war and a grating personality.

In July 1943, Borovicka was finally dispatched to a remote outpost near Kooskia, Idaho, where the INS ran a road camp administered by officials of Fort Missoula, 120 miles to the east. Earlier, a Japanese physician, known as Dr Tsuneyoshi Koba, was detailed to Kooskia from Fort Missoula. To the embarrassment of the INS, he was soon exposed as a fake. Not only had he failed to complete a surgical residency at Johns Hopkins Hospital as claimed, he was not a physician at all. Thus, Dr Borovicka became the camp's first legitimate doctor.[31]

Here, 140 Japanese volunteers from other INS camps worked on constructing the Lewis and Clark Highway that would link Missoula and Lewiston via Lolo Pass, near the camp. The appeal of this dangerous work was the promise of prevailing wages while working in a setting where trees and rugged terrain, not guard towers, discouraged escape. Because the operation of heavy machinery and the handling of explosives was involved, and because the nearest hospital was more than 60 miles away, an onsite physician became a high priority.[32] Without nearby medical help, a serious accident might provoke the feared reprisals against Americans held in Asia. Such anxieties seemed justified when details of the earlier deaths of 3 Japanese detainees at Fort Missoula entered diplomatic channels.

Source. Immigration and Naturalization Service.

Dr Ludovicko Borovicka near the time of his detention by the INS in 1941.

A DIPLOMATIC CRISIS

On October 27, 1942, the Spanish Embassy, which represented Japan's interests in the United States, forwarded to the State Department a cablegram, based on reports received from repatriated Japanese earlier that summer, that protested the deaths of 3 elderly Japanese in US custody.[33] The message expressed astonishment "at the most inhuman cruelty and insult inflicted upon [Japanese nationals] by the United States Authorities in the course of their arrest, examination, internment and transport." Contained within the body of a 6-part complaint was

the charge that 3 Japanese subjects of advanced age who died at Fort Missoula were invalids from the time of their arrest, but that their ill health went unattended and hastened their demise.[34]

Such behavior, if true, could be perceived by the Japanese as a violation of the rules of conduct laid down by the Geneva Convention, and reprisals against American civilians in Asia might ensue. The State Department replied on December 12, 1942, promising a thorough investigation "with a view to removing the causes of legitimate complaints and taking appropriate disciplinary action with regard to them."[35]

Investigators consulted medical records and interviewed medical personnel and Fort Missoula staff. After reviewing the available evidence, the investigation team concluded that the standard of care for medical practice had been met. Three Japanese detainee doctors had attended 1 case, and in 2 cases family members thanked INS administrators for courtesies extended to the detainees during the course of treatment. This report was transmitted to the Japanese Government through the Swiss Legation on October 16, 1943.[36]

The ultimate truth to this story may remain sandwiched between the "facts" of the charges and the "facts" of the follow-up investigation. The State Department, for example, avoided explaining why 2 of the detainees, not only physically ill but showing advanced signs of dementia, posed such a threat to national security as to justify arrest and detention. Nevertheless, that the incident reached the diplomatic level points to the serious nature of the charges and the lengths to which the State Department went to respond in the face of potential consequences to American citizens held in Asia. This incident must have remained on the minds of State Department and INS officials for the duration of the war.

TRICHINOSIS AT FORT STANTON

Another potential threat to Americans held abroad was an epidemic among the German seamen at Fort Stanton. On the evening of February 9, 1942, thirty-five former crew members of the *Columbus* fell victim to an outbreak of food poisoning. Within hours, 145 of the 400 seamen complained of diarrhea, headache, vomiting, widespread aches and pains, swelling, and fever. Seventeen men required immediate hospitalization, one of whom later died from cardiac complications. All evidence pointed to trichinosis from pork sausage produced by the internees in their own kitchen.

Dr G.M. Kunkel, chief medical officer of the nearby US Marine Hospital, called for reinforcements as the number of victims escalated. Two outside doctors, 1 pathologist, and 2 nurses arrived on the scene, augmented by 15 locally employed orderlies and 7 public health nurses.[37]

By the end of the first week, 72 cases had been sent by gurney to the hospital. In all, 278 seamen eventually required bed care, and most of the others revealed mild clinical symptoms. Since orderlies were in short supply, crewmen exhibiting the fewest symptoms were pressed into service.

By mid-March, the crisis was over. While 9 crew members remained at the hospital, the others were well or recuperating in their barracks. Closely observing the unfolding events was the Swiss Legation in Washington, DC, representing Germany's diplomatic interests in the United States. Because of minimal loss of life and the involvement of the Public Health Service, the harrowing incident produced no diplomatic backlash.[38]

Minor outbreaks of food poisoning hampered smooth operations at INS internment camps throughout the war, occupying the attention of medical personnel everywhere. In addition, staff shortages, supply shortages, and shifting populations plagued the USPHS and the INS. But as World War II ground to an end in the summer of 1945, camp populations began to dwindle. The seamen were finally repatriated and interned enemy aliens returned to their prewar communities. By the end of 1945, only the Crystal City, Santa Fe, and Fort Lincoln camps remained open, with most residents awaiting the outcome of repatriation or deportation proceedings. Eventually, camp hospitals and clinics were disassembled and permanent medical staff received new assignments.

OVERALL HEALTH CARE PROVIDED

The amount of health care provided to the interned community is difficult to assess for want of complete data. At the Crystal City family camp, where the population averaged more than 2000, over a 34-month period the medical staff admitted 1770 patients and performed 204 major operations. More than 11 000 house calls were made and 30 000 prescriptions written. The hospital logged 155 live births. A total of 9200 immunizations were scratched onto and injected into arms against smallpox, typhoid, diphtheria, and whooping cough. And 1298 residents received eye examinations and new glasses.[39]

Such numbers would be more meaningful, however, if compared with patient care experiences on the home front during the same time period. An in-depth study of health care for Americans in World War II awaits future research. However, some comparisons of access to care between the 2 populations are possible and may be informative.

The war took a tremendous toll on the distribution of the nation's 155 000 active physicians and the availability of services to the populace. Nearly one third of doctors entered military service, representing the youngest, the best trained, and those capable of providing the most efficient and sophisticated care.[40] In 1940, public health officials estimated the ideal number of physicians to be 1 doctor per 1000 people.[41] By January 1944, only 43% of Americans lived in areas where more than 1 doctor was available for every 1500 people. The Public Health Service had earlier established this ratio to be the minimum standard necessary to preserve the nation's health. In 7 states, the availability did not even reach 1 doctor for every 2000 civilians.[42] Physicians in rural communities flocked to urban areas to fill the void left by clinicians entering military service. Others migrated to areas where war materiel was being assembled by exploding numbers of migrating defense workers, whose adopted communities were desperate for medical personnel.[43] The rate of available hospital beds deteriorated during the war, as wards were shut down

because the minimum number of nurses needed to safely staff them could not be recruited. This brought a nationwide change in maternity practice, as new mothers' average postpartum stays plummeted from 9 to a single day.[44] For the first time, busy doctors began to move away from the time-honored tradition of making house calls.

By contrast, internees in the hospitals and clinics run by the Public Health Service had almost universal access to health care. With the combined presence of USPHS, contract, and internee doctors, medical coverage for the imprisoned population reached 1 doctor per 400 internees, a rate nearly 4 times better than the national rate. Many internees and their families probably received more comprehensive care than they ever had before the war.

The number of available hospital beds reached 35 per 1000 internees, 10 times higher than the national rate.[45] When facilities or the skills of the doctors failed to meet the need, internees had access to outside civilian or military hospitals. Finally, virtually all internees received immunizations against epidemic diseases, a public health goal not achieved on behalf of the American people by the end of the war.

Certainly individual politically, ethnically, and racially motivated medical abuses occurred throughout the war, and the medical standard of care was no doubt compromised during periods of acute shortages and due to the incompetence of individuals. However, these commissions and omissions did not represent an INS policy. Nor did they reflect the mission of the USPHS, with its long tradition of protecting the health of the nation's desirables as well as its undesirables.[46]

The Public Health Service proved to be a savior to the INS, which supervisor W.F. Kelly freely acknowledged to the surgeon general shortly after the end of the war.[47] Accolades came from the internees themselves. Following the crisis at Fort Stanton, Captain Daehne directed a letter of thanks to Dr Kunkel through the camp commander "expressing to you my sincere thanks for the most energetic steps, which the Department of Public Health has taken to combat the outbreak of trichinosis in our camp." He further requested that Kunkel's staff be made aware of the appreciation of his crew, many of whom were ardent Nazis.[48]

The subject of health care for civilians in the United States during World War II remains a fertile field for investigation. To date, a comprehensive study of health care for Americans is lacking, despite a vast historical literature devoted to the home front.[49] Consequently, it remains unclear how health care in the INS camps compared with that for the majority of Americans who were asked to bear the brunt of the loss of medical resources to the armed services. Also needed is a detailed comparison between the health care experience of the INS internees and of Japanese Americans in army and War Relocation Authority camps, where the protections of the Geneva Convention were not guaranteed and where prescribed medical oversight failed to include the USPHS.[50]

Nevertheless, the available evidence suggests that in the presence of scarce human and medical resources, the INS, in partnership with the US Public Health Service, succeeded in providing comprehensive health care to 20 000 Axis noncombatants whose motherlands were at war with the United States.

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Endnotes

1. *Personal Justice Denied: Report of the Commission on Wartime Relocation and Interment of Civilians* (Seattle: University of Washington Press, 1997), 18. The literature on the incarceration of Japanese Americans in World War II is vast. For an excellent primer on the subject, see Roger Daniels, *Prisoners Without Trial: Japanese Americans in World War II* (New York: Hill and Wang, 1993).

2. Section 21, Title 50, United States Code. Historians employ distinct terminology to describe the 2 imprisonment experiences in order to avoid confusion between an *incarceration* that was lawless and an *internment* that was a specific legal process. It should be noted that many Japanese nationals throughout the country were interned as enemy aliens following the bombing of Pearl Harbor. Most other US resident Japanese nationals were incarcerated in the spring of 1942.

3. The Immigration and Naturalization Service (INS) was transferred from the Department of Labor to the Justice Department in 1940.

4. John Joel Culley, "A Troublesome Presence: World War II Internment of German Sailors in New Mexico," *Prologue: Quarterly of the National Archives and Records Administration* 28 (1996): 279–295.

5. John Christgau, *"Enemies": World War II Alien Internment* (Ames: Iowa State University Press, 1985), 9.

6. Culley, "A Troublesome Presence," 285–286.

7. Memorandum for the file, June 16, 1941, W.F. Kelly, box 2160, file 56086/100-A, Records Related to the Detention and Internment of Enemy Aliens During World War II, Records of the Immigration and Naturalization Service (RG85), National Archives, Washington, DC.

8. Alan M. Kraut, *Silent Travelers: Germs, Genes, and the "Immigrant Menace"* (New York: Basic Books, 1994), 50–77.

9. Fitzhugh Mullan, *Plagues and Politics: The Story of the United States Public Health Service* (New York: Basic Books, 1989), 96.

10. Ralph Chester Williams, *The United States Public Health Service, 1798–1950* (Washington, DC: US Public Health Service, 1951), 613–615.

11. For a discussion of health care in the assembly centers, see Louis Fiset, "Public Health in World War II Assembly Centers for Japanese Americans," *Bulletin of the History of Medicine* 73 (1999): 565–584.

12. Internal memo, W.F. Kelly, April 24, 1941, box 2160, file 56086/100-A, RG85.

13. Williams, *The United States Public Health Service*, 1798–1950, 631.

14. *Ibid*, 636–637.

15. A.S. Hudson to W.F. Kelly, July 4, 1941, box 2167, file 56086/150, RG85.

16. Francis Biddle to Thomas Parran, July 26, 1941, box 719, General Classified Files, file 0125–Aliens 1940–, Records of the US Public Health Service (RG90), National Archives, Washington, DC.

17. W.F. Draper to Francis Biddle, August 6, 1941, box 719, file 0125, RG90.

18. Capt. Stengler to Capt. Daehne, July 5, 1942, file 4290/272–Borovicka, Dr. L.R., World War II Internment Files, General Files–Fort Lincoln, RG85.

19. T.D. Quinn to Surgeon General, December 5, 1941, box 719, file 0125, RG90.

20. For texts of proclamations 2525, 2526, and 2527, see *American Concentration Camps*, vol. 1, ed. Roger Daniels (New York: Garland, 1989). For arrest and detention figures, see "Report of Enemy Aliens in Temporary Detention," December 31, 1941, box 2410, file 56125/35, RG85. A year later, on December 31, 1942, 10 037 had been received into temporary custody under presidential warrant. The total includes 4112 Germans, 4232 Japanese, 1478 Italians, and 215 "others." Memorandum for Mr. Charles E. Waller, January 13, 1943, box 2411, file 56215/35-E, RG85.

21. John Joel Culley, "Enemy Alien Control in the United States During World War II: A Survey," in *Alien Justice: Wartime Internment in Australia and North America*, ed. Kay Saunders and Roger Daniels (Brisbane, Australia: University of Queensland Press, 2000), 145.

22. This estimate breaks down to 11 000 US resident enemy aliens, 1700 Axis seamen, and 6600 Axis deportees from 15 Latin American countries. Roger Daniels, "Words Do Matter: A Note on Inappropriate Terminology and the Incarceration of the Japanese Americans." In Louis Fiset and Gail M. Nomura eds., Nikkei *(Dis) Appearances: Twentieth Centry Japanese American and Japanese Canadian History in the Pacific Northwest* (Seattle: University of Washington Press, in press). The 1 million includes 695 363 Italians, 314 715 Germans, and 91 858 Japanese.

23. *Foreign Relations of the United States: Diplomatic Papers*, 1942, vol. 1 (Washington, DC: US Department of State, 1960), 792.

24. "Multilateral Convention—War Prisoners. July 27, 1929," United States Statutes at Large, Vol 47, Part 2, 2021–2073.

25. For a discussion of the deportation of Japanese Latin Americans to the United States in World War II, see Thomas Connell, *America's Japanese Hostages: The World War II Plan for a Japanese Free Latin America* (Westport, Conn: Praeger Press, 2002); C. Harvey Gardiner, *Pawns in a Triangle of Hate: The Peruvian Japanese and the United States* (Seattle: University of Washington Press, 1981); and Seiichi Higashide, *Adios to Tears: The Memoirs of a Japanese-Peruvian Internee in US Concentration Camps* (Seattle: University of Washington Press, 2000). For German deportees, see Max Friedman, *Nazis and Good Neighbors: The United States Campaign Against the Germans of Latin America in World War II* (New York: Cambridge University Press, 2003).

26. N.D. Collaer to INS Commissioner, February 15, 1943, box 2433, file 56125/95–Hospitalization Records, Crystal City, RG85; Symmes F. Oliver to Surgeon General, March 2, 1943, box 2433, file 56125/95–Hospitalization Records, Crystal City, RG85.

27. Symmes F. Oliver to Surgeon General, March 2, 1943, box 2433, file 56125/95–Hospitalization Records, Crystal City, RG85.

28. "Confidential Efficiency Report–Symmes Oliver," June 1943, box 2433, file 56125/95–Hospitalization Records, Crystal City, RG85.

29. J.L. O'Rourke to W.F. Kelly, April 25, 1944, box 2433, file 56125/95–Hospitalization Records, Crystal City, RG85.

30. World War II Internment Files, General Files–Fort Lincoln, file 4290/272–Borovicka, Dr. L.R., RG85.

31. This arrangement lasted 7 months. Restrictions against resident Italian nationals were lifted on Columbus Day, 1942. Once Italy was out of the war, by fall 1943, most Italian internees were released from custody. Borovicka, who for once must have been happy to be an Italian, was paroled to Chicago on February 1, 1944. He was replaced by a German internee physician from the Kenedy Internment Camp, Dr. Hans Werner Kempski, who cared for the Japanese internees until the closure of the road camp in May 1945. See World War II Internment Files, General Files–Fort Lincoln, file 4290/272–Borovicka, Dr. L.R., RG85.

32. World War II Internment Files, General Files–Fort Lincoln, file 4290/272–Borovicka, Dr. L.R., RG85. For a detailed description of the Kooskia Camp, see Priscilla Wegars, "'A Real He-Man's Job': Japanese Internees and the Kooskia Internment Camp, Idaho, 1943–1945," Asian American Comparative Collection, University of Idaho, Moscow.

33. Two exchanges of Japanese and American civilians took place, in 1942 and 1943. For details, see P. Scott Corbett, *Quiet Passages: The Exchange of Civilians Between the United States and Japan During the Second World War* (Kent, Ohio: Kent State University Press, 1987).

34. *Foreign Relation of the United States*, Vol III, 1050–1055.

35. *Ibid*, 1055–1059.

36. *Ibid*, 1073–1080. It is not known whether these deaths had an adverse direct impact on the lives of American civilians interned in Asia.

37. G.C. Wilmoth to INS Commissioner, February 17, 1942, General Files–Fort Stanton, file 56066/600, RG85.

38. W.F. Kelly to Lemuel B. Schofield, March 20, 1942, General Files–Fort Stanton, file 56066/600, RG85.

39. "Historical Narrative of the Crystal City Internment Camp," September 15, 1945, World War II Internment Files, General Files–Crystal City, box 1, file 101/061–Camp Progress, Narratives and Reports, RG85.

40. George Q. Flynn, "American Medicine and Selective Service in World War II," *Journal of the History of Medicine* 42 (1987): 305–326.

41. Frederick D. Mott and Milton I. Roemer, *Rural Health and Medical Care* (New York: McGraw-Hill, 1948), 155.

42. *Ibid*, 206–207.

43. US Army Medical Service, Medical Department of the United States Army, *Personnel in World War II* (Washington, DC: Office of the Surgeon General, 1963), 193–195.

44. Elizabeth Temkin, "Driving Through: Postpartum Care During World War II," *American Journal of Public Health* 89 (1999): 587–595.

45. "Field Trip Report," C.D. Head, Jr, to K.E. Miller, September 15, 1943, box 2433, file 56125/95–Hospitalization Records, Crystal City, RG85; Mott and Roemer, *Rural Health and Medical Care*, 226–227.

46. This tradition is not without its pock marks. For example, in 1972 the Public Health Service was thrown into an ethical crisis for its role in the 40-year-long Tuskegee Syphilis Project involving the long-term, clinical course of Black enrollees with advanced, untreated syphilis. Despite the proven effectiveness of penicillin against syphilis, untreated cases were allowed to continue. See James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (New York: Free Press, 1981).

47. W.F. Kelly to Thomas Parran, February 18, 1946, box 719, file 0125, RG90.

48. Capt. W. Daehne to Dr. G.M. Kunkel, March 16, 1942, General Files–Fort Stanton, file 56066/600, RG85.

49. For a general history of the home front, see Geoffrey Perrett, *Days of Sadness, Years of Triumph: The American People, 1939–1945* (Madison: University of Wisconsin Press, 1985).

50. A small body of literature exists on health care in the War Relocation Authority centers. See, for example, Louis Fiset, "Health Care at the Central Utah (Topaz) Relocation Center," *Journal of the West* 38 (1999): 34–44; Louis Fiset, "The Heart Mountain Hospital Strike of June 24, 1943," in *Remembering Heart Mountain Essays on Japanese American Internment in Wyoming*, ed. Mike Mackey (Powell, Wyo: Western History Publications, 1998), 101–118; Susan L. Smith, "Women Health Workers and the Color Line in the Japanese American 'Relocation Centers' of World War II," *Bulletin of the History of Medicine* 73 (1999): 585–601; Gwenn M. Jensen, "System Failure: Health-Care Deficiencies in the World War II Japanese American Detention Centers," *Bulletin of the History of Medicine* 73 (1999): 602–628; and Susan McKay, *The Courage Our Stories Tell: The Maternal Lives and Child Health Care of Japanese American Women at Heart Mountain* (Powell, Wyo: Western History Publications, 2002).